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COST-EFFECTIVENESS OF USING HYDROXYUREA TO TREAT SICKLE CELL ANEMIA IN UGANDA: A MODEL-BASED COMPARISON OF TWO DOSING REGIMENS

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Background Recognition of the burden of sickle cell anaemia (SCA) in sub-Saharan African (SSA) countries is increasing, with few therapies available for clinical management. Hydroxyurea is the only disease-modifying therapy that has proven feasible and clinically efficacious in low-income countries in SSA; however, the health economic implications of its use in this region have not been quantified. Thus, we examined the incremental cost-effectiveness of hydroxyurea given as a fixed-dose regimen or at the maximum tolerated dose (MTD).

Methods We estimated the cost of outpatient treatment at a specialized sickle cell clinic in Kampala, Uganda, from a provider's perspective. These estimates were used in a discrete-event simulation model to project mean costs (US\$), disability-adjusted life years (DALYs), and consumption of blood products per patient (450 ml units). We calculated cost-effectiveness as the ratio of incremental costs over incremental DALYs averted, discounted at 3% annually.

Findings For Ugandan patients under the age of 18, we predicted that hydroxyurea at the MTD would avert an expected 1.38 DALYs and save US\$ 111 per patient compared to standard care, while hydroxyurea at a fixed dose would avert 0.81 DALYs per patient at an incremental cost of US\$ 21. Additionally, we predicted that the fixed-dose alternative would save 9.2 (95% CI 9.0–9.3) units of whole-blood equivalents per patient, while the MTD strategy saved 11.3 (95% CI 11.1–11.4) units of blood per patient.

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HEALTH CARE INEQUALITY IN UNJUST CIRCUMSTANCE – SRI LANKA EXPERIENCE

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Objective Sri Lanka has earned a strong reputation for ensuring universally accessible free health and education, gender equality and opportunity for social mobility since her independence. Nevertheless, during the period of protracted civil war, country encountered many challenges to ensure the viability of the social benefits equally throughout the country.

The main purpose of this study was to evaluate the impact of conflict on inequalities in health services provision and health outcomes between direct conflict-affected area and other areas of the country during the conflicts and early phase of the post-conflict period.

Method The main hypothesis of this study was internal conflict negatively affected to the health system in Northern Province and created a health inequality comparing rest of the country. The input process outcome model approach was used for analyzing the inequality in relation to investment to the health, health services provision and health status. Data sources were the Central Bank of Sri Lanka, Department of Census and Statistics, the Ministry of Health, United Nations Development Program and the World Bank.

Results There was a substantial shortage of key health care workers in the direct conflict-affected area during the in-conflict period. However, the government hospital beds density remains higher during the conflicts period and has been increased dramatically in early phase of the post conflict period. Low birth weight prevalence was less and there was no significant difference of major communicable diseases prevalence comparing with the national level.

Although Northern Province showed similar reducing trend of Infant Mortality Rate (IMR) with national level from 1997 to 2016, the Maternal Mortality Ratio (MMR) was significantly higher in Northern Province during the same period.

Conclusion This study reveals even though conflict related health inequalities are unavoidable, it was remained less in Northern Province in Sri Lanka during armed conflict period.

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EQUITY, JUSTICE, AND SOCIAL VALUES IN PRIORITY SETTING: A QUALITATIVE STUDY OF RESOURCE ALLOCATION CRITERIA FOR GLOBAL DONOR ORGANIZATIONS WORKING IN LOW-INCOME COUNTRIES

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Background There is increasing acceptance of the importance of social values like equity and fairness in health care priority setting (PS). However, equity is difficult to define; it means different things to different people. How equity is understood in theory, may not align with how it is operationalized. There is limited literature on how development assistance partner organizations (DAP) conceptualize and operationalize equity in their health care prioritization decisions for low-income countries (LIC). We explore whether and how equity is a consideration in DAP's PS processes.

Methods A qualitative study involving 35 in-depth interviews with DAPs involved in health-system PS for LICs and review of their respective webpages.

Results While several PS criteria were identified, direct articulation of equity as an explicit criterion was lacking. However, equity was implied, by some responses, through prioritizing of vulnerable populations. Where mentioned, respondents discussed the difficulties of operationalizing equity, since vulnerability is associated with several, competing factors including gender, age, geography, and income. Some respondents suggested that equity could be operationalized through organizations' lack of support for programs that reinforce pre-existing inequities.

Although several organizations' webpages identify addressing inequities as a guiding principle, they varied in their discussion its operationalization. While intersectionalities in vulnerabilities

complicate its operationalization, if the various organizations explicitly articulate their equity focus, each organization may concentrate on different dimensions of vulnerability. Thus, all organizations will contribute to achieving equity in all the relevant dimensions.

Conclusions Since most DAPs support some form of equity, we highlight a need for an internationally recognized framework that recognizes the intersectionalities of vulnerability, for mainstreaming and operationalizing equity in DAP priority setting and resource allocation. This framework will support consistent conceptualization and operationalization of equity in global health programs. The degree to which equity is actually integrated in these programs merits further study.

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THE ROLE OF PRIORITY SETTING IN PANDEMIC PREPAREDNESS AND RESPONSE: A COMPARATIVE ANALYSIS OF COVID-19 PANDEMIC PLANS IN 12 COUNTRIES IN THE EASTERN MEDITERRANEAN REGION

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Background The COVID-19 pandemic has significantly disrupted health systems in the Eastern Mediterranean Region (WHO-EMRO), where over half of the countries are affected by armed conflict. Active humanitarian and refugee crises have led to mass population displacement and increased health system fragility. This has exacerbated pre-existing resource gaps and increased competition for meager resources. With large proportions of vulnerable populations - refugees, migrants, and internally displaced people (IDPs) - their explicit consideration in planning documents is critical if equitable priority setting is to be realized during the pandemic. We examine what and how priority setting (PS) was included in national COVID-19 pandemic plans within the region.

Methods An analysis of COVID-19 pandemic response and preparedness planning documents from a sample of twelve purposively selected countries in WHO-EMRO. We assessed the degree to which documented PS processes adhere to twenty established quality indicators of effective PS from Kapiriri & Martin's framework.

Results While all reviewed plans addressed some aspect of PS, none included all quality parameters. Yemen's plan included the most quality parameters (12), while Egypt's addressed the least (4). Publicity of priorities was common to all plans. The next most commonly identified parameter was use of evidence to guide planning and PS. When considering equity as a PS criterion, despite the high concentration of refugees, migrant, and IDPs in the region, only a quarter of the plans prioritized these populations.

Discussion When setting priorities in health emergencies, context is paramount. In areas experiencing conflict and crisis, PS can be an undemocratic and challenging process. Health system fragmentation is key contributor to COVID-19 inequities experienced across the EMRO region. Limited prioritization of vulnerable groups like refugees, migrant, and IDPs in planning documents, will have long-term health implications and

exacerbate the disproportionate burden of COVID illness and death for these groups.

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PRIORITISATION OF COVID-19 VACCINES: WHAT KIND OF EXPERTISE CAN ETHICISTS OFFER?

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Objective The political costs associated with healthcare priority-setting give decision-makers an incentive to shield from the consequences of unpopular decisions. This fact, together with the factual and normative complexity of priority-setting decisions, give politicians reason to delegate decision-making through arrangements such as consultative procedures and to seek the advice of moral and political philosophers. Not surprisingly, many countries made use of ethics expert panels to advice on priority setting of COVID-19 vaccines in the first phase of the pandemic. However, the authority of a distinctive expertise in ethical guidance was being questioned in the public debate on vaccine prioritisation. This sceptical stance regarding the role and expertise of the ethics expert is not new. If we are all equal as autonomous beings and autonomy is the source of normativity, then we all have equal capacity for moral decision-making. The aim of this paper is to examine if and how ethics expertise can contribute to policy making regarding the development and implementation of COVID-19 immunisation programmes: What kind of expertise can ethicists offer?

Methods Theoretical discussion based on an illustrative case: Domestically prioritisation of COVID-19 vaccines.

Results and Discussion We argue that ethicists have an epistemic authority in the sense of being in a privileged position to give ethical advice if a set of meta-principles for regulation of the ethical debate is followed. By using a methodology of 'engaged philosophy', the ethics experts should seek to identify relevant values in the context of a specific problem and work through a series of steps so that broad agreement can be made in a given case. While we may not necessarily converge on the deepest foundations for our normative beliefs, we may reach agreement particular outcomes and mid-level principles.

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NATIONAL ADAPTATION AND IMPLEMENTATION OF THE WHO MODEL LIST OF ESSENTIAL MEDICINES: A QUALITATIVE EVIDENCE SYNTHESIS

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Access to essential medicines is a key component of Universal Health Coverage, and the World Health Organization's Model List of Essential Medicine (WHO EML) has played a critical role in guiding the country-level selection and financing of medicines for more than four decades. This study identified factors affecting adaptation and implementation of the WHO Model List of Essential Medicines (WHO EML) at the national level.